Workers' Compensation Training

Human Resources & Employee Development
Valdosta State University

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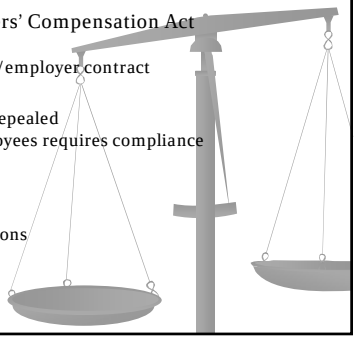
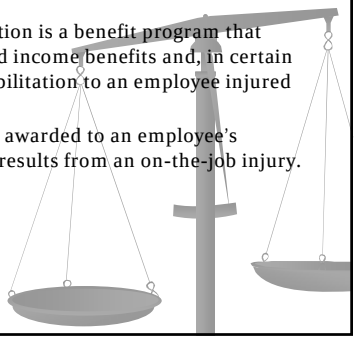
General History

- 1920, Georgia Workers' Compensation Act
  - Elective coverage
  - Presumed employee/employer contract
- 1972
  - Elective provisions repealed
  - Three or more employees requires compliance
- Exceptions
  - Railroad workers
  - Farm laborers
  - Real estate salespersons
  - Domestic workers



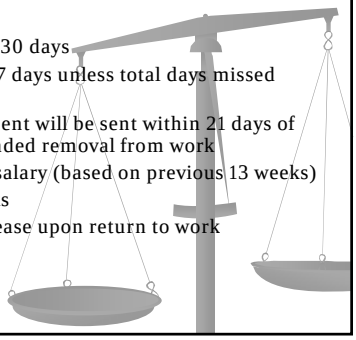
Definition

- Workers' Compensation is a benefit program that provides medical and income benefits and, in certain circumstances, rehabilitation to an employee injured on the job.
- Benefits may also be awarded to an employee's dependents if death results from an on-the-job injury.



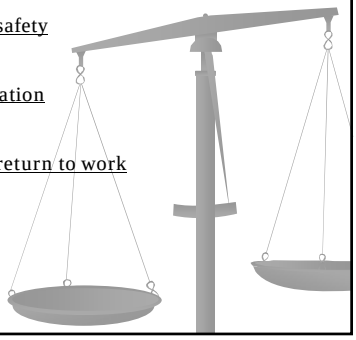
Overview of Benefits

- Immediate coverage
- Report claim within 30 days
- Benefits begin after 7 days unless total days missed exceeds 21
- Compensation payment will be sent within 21 days of physician recommended removal from work
- Awards 2/3 of your salary (based on previous 13 weeks)
- Maximum 400 weeks
- Benefits reduce or cease upon return to work



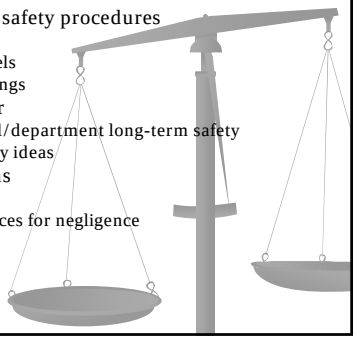
Supervisor's Role

- Promote workplace safety
- Be proactive
- Maintain communication
- Document clearly
- Facilitate employee return to work



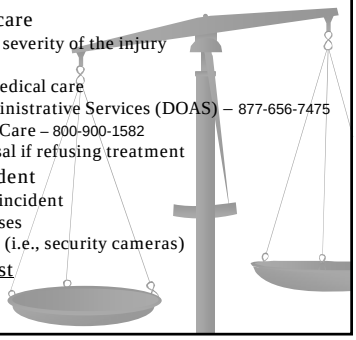
Promote Workplace Safety

- Inform employees of safety procedures
  - Post safety policies
  - Display warning labels
  - Require safety trainings
- Reward safe behavior
  - Recognize individual/department long-term safety
  - Encourage new safety ideas
- Correct unsafe actions
  - Retrain employees
  - Establish consequences for negligence



Be Proactive

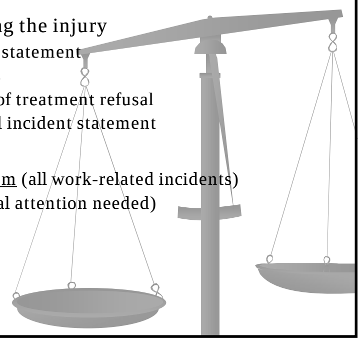
- Immediate medical care
  - Promptly assess the severity of the injury
  - Administer first aid
  - Seek professional medical care
  - Department of Administrative Services (DOAS) – 877-656-7475
  - AmeriSys Managed Care – 800-900-1582
  - Obtain written refusal if refusing treatment
- Investigation of incident
  - Observe the area of incident
  - Consult with witnesses
  - Check other sources (i.e., security cameras)
- Step-by-step checklist



Maintain Communication

- Employee
  - Listen to the employee's description of the incident and injury
  - Write a clear incident report
  - Provide AmeriSys contact information
    - 678-781-2848
    - 800-900-1582
  - Maintain objectivity
  - Keep in contact with the employee through the entire process

Document Clearly



- Statements regarding the injury
  - Injured employee's statement
  - Witness statements
  - Written statement of treatment refusal
  - Supervisor's critical incident statement
- Forms
  - Incident Notice Form (all work-related incidents)
  - WC-1 (when medical attention needed)

FOR REPORTING PURPOSES ONLY

INCIDENT NOTICE ONLY

Instructions: For occupational injuries requiring medical attention or lost work days, call the **Human Resources and Employee Development Department at 5709** immediately upon notification of the injury. Use **this form if no injury is claimed and/or no medical treatment was needed.**

Date incident reported by employee ________________

Name of injured employee ____________________ Office phone# ____________

Job Title ____

Social Security # ____________________

Date of incident ______________ Time of incident ______________

Description of incident (how, where, why?) ________________________

____

____

Type of injury (cut, scrape, burn, etc.) ________________________

Place of occurrence (provide address if possible) ____________________

Was First Aid administered at time of incident? Yes ____ No ____ What type? ________

Witnesses (provide names and contact numbers) ____________________

____

Supervisor's name ____________________ Telephone # ____________

Person completing report ____________________ Telephone # ____________

Date Report completed ____________

This form does not replace the WC-1, Employer's First Report of Injury. This form should be kept as part of the employee's personnel file and forwarded to Human Resources and Employee Development by fax (229) 259-5030.

Updated 7/04

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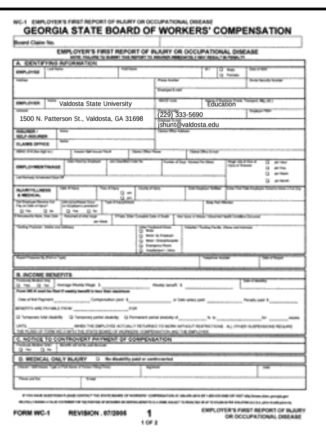

WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Board Claim No.

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

A. IDENTIFYING INFORMATION

EMPLOYEE

EMPLOYER Valdosta State University Education

1500 N. Patterson St., Valdosta, GA 31698 (229) 333-5690 jshunt@valdosta.edu

INSURER / SELF-INSURER

CLAIMS OFFICE

EMPLOYMENT/WAGE

INJURY/ILLNESS & MEDICAL

B. INCOME BENEFITS

C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

D. MEDICAL ONLY INJURY

FORM WC-1 REVISION . 07/2005 1 1 OF 2 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

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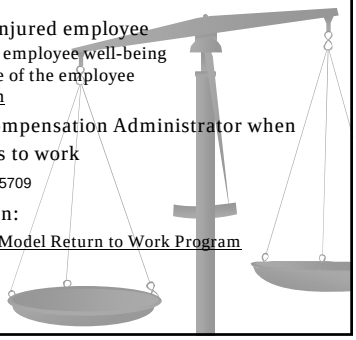
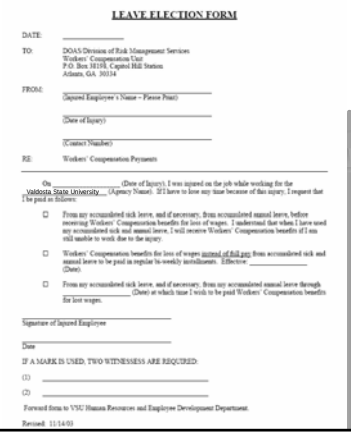
Facilitate Return to Work

- Communicate with injured employee
  - Express concern for employee well-being
  - Emphasize the value of the employee
  - Leave Election Form
- Contact Workers' Compensation Administrator when the employee returns to work
  - Judy Hart – 229.333.5709
- For more information:
  - Georgia State Board Model Return to Work Program





LEAVE ELECTION FORM

DATE: _____

TO: DOAS Division of Risk Management Services
Workers' Compensation Unit
P.O. Box 38198, Capitol Hill Station
Atlanta, GA 30334

FROM: _____
(Injured Employee's Name – Please Print)

_____
(Date of Injury)

_____
(Contact Number)

RE: Workers' Compensation Payments

On _____ (Date of Injury), I was injured on the job while working for the Valdosta State University (Agency Name). If I have to lose any time because of this injury, I request that I be paid as follows:

☐ From my accumulated sick leave, and if necessary, from accumulated annual leave, before receiving Workers' Compensation benefits for loss of wages. I understand that when I have used my accumulated sick and annual leave, I will receive Workers' Compensation benefits if I am still unable to work due to the injury.

☐ Workers' Compensation benefits for loss of wages instead of full pay from accumulated sick and annual leave to be paid in regular bi-weekly installments. Effective: _____ (Date).

☐ From my accumulated sick leave, and if necessary, from my accumulated annual leave through _____ (Date) at which time I wish to be paid Workers' Compensation benefits for lost wages.

_____
Signature of Injured Employee

_____
Date

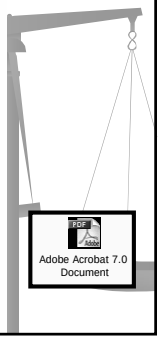
IF A MARK IS USED, TWO WITNESSES ARE REQUIRED:

(1) _____

(2) _____

Forward form to VSU Human Resources and Employee Development Department.

Revised: 11/14/03



Concluding Remarks

- Following the policies and procedures introduced in this training will allow you, as a supervisor, to prevent and, if necessary, legally handle any workers' compensation issues that may occur.
- Please utilize the additional information included in this training to gain more specific information regarding a variety of workers' compensation issues.
  - Frequently Asked Questions
  - Georgia State Board Procedure Manual
  - Georgia State Board Supervisor's Manual